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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>8000879</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>HILLSBORO HSP EXTRA CARE FAC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/03</u> to <u>06/30/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1200 E. TREMONT</u> <u>HILLSBORO</u> <u>62049</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>MONTGOMERY</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(217) 532-6111</u> Fax # <u>(217) 532-2726</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
IDPA ID Number: <u>076972</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>09/06/1975</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(C)(3)</u>		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact Name: _____ Telephone Number: <u>(217) 532-6111</u>			

STATE OF ILLINOIS

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Facility Name & ID Number HILLSBORO HSP EXTRA CARE FAC# 8000879 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>40</u>	Skilled (SNF)	<u>40</u>	<u>14,600</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>40</u>	TOTALS	<u>40</u>	<u>14,600</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,369</u>	<u>570</u>	<u>2,688</u>	<u>4,627</u>	8
9	SNF/PED					9
10	ICF	<u>3,049</u>	<u>1,052</u>		<u>4,101</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,418</u>	<u>1,622</u>	<u>2,688</u>	<u>8,728</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 59.78%

D. How many bed-hold days during this year were paid by Public Aid?

_____(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NORMAL HOSPITAL ANCILLARIES

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location

Date started 09/06/1975

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 28 and days of care provided 2,477Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAU ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	132,585	136,197		268,782	(68,582)	200,200		200,200		1
2	Food Purchase					68,582	68,582		68,582		2
3	Housekeeping	48,585	4,099		52,684		52,684		52,684		3
4	Laundry	54,210	20,243		74,453		74,453		74,453		4
5	Heat and Other Utilities					36,758	36,758		36,758		5
6	Maintenance	31,926	49,311		81,237	(36,758)	44,479		44,479		6
7	Other (specify):*										7
8	TOTAL General Services	267,306	209,850		477,156		477,156		477,156		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	710,445	152,565		863,010		863,010		863,010		10
10a	Therapy										10a
11	Activities										11
12	Social Services	1,989	3,400		5,389		5,389		5,389		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	712,434	155,965		868,399		868,399		868,399		16
	C. General Administration										
17	Administrative	84,601	187,543		272,144		272,144		272,144		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotion										20
21	Clerical & General Office Expense	82,362	11,034		93,396		93,396		93,396		21
22	Employee Benefits & Payroll Tax										22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	166,963	198,577		365,540		365,540		365,540		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,146,703	564,392		1,711,095		1,711,095		1,711,095		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **HILLSBORO HSP EXTRA CARE FAC**

#8000879

Report Period Beginning:

07/01/03

Ending:

06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			19,064	19,064		19,064		19,064			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle											35
36	Other (specify): ^a											36
37	TOTAL Ownership			19,064	19,064		19,064		19,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:	160,912		140,266	301,178		301,178		301,178			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee											42
43	Other (specify): ^a PROVIDER TAX							21,960	21,960			43
44	TOTAL Special Cost Centers	160,912		140,266	301,178		301,178	21,960	323,138			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	1,307,615	564,392	159,330	2,031,337		2,031,337	21,960	2,053,297			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **HILLSBORO HSP EXTRA CARE FAC**# **8000879**

Report Period Beginning:

07/01/03

Ending:

06/30/04**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program	NOTE: PLEASE REFER TO THE MEDICARE COST REPORT WORKSHEET A-8 FOR EXPENSE ADJUSTMENTS NOT SCHEDULED HERE.			3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotion				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		X	\$		38
39						39
40	Gift and Coffee Shop		X			40
41	Barber and Beauty Shop		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

HILLSBORO HSP EXTRA CARE FAC

ID# 8000879

Report Period Beginning: 07/01/03

Ending: 06/30/04

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
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27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/04

(to Sch V, co

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$	N/A		\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number HILLSBORO HSP EXTRA CARE FAC # 8000879 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HILLSBORO HSP EXTRA CARE FAC # 8000879 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1							\$	\$		\$	1
2	N/A										2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related						\$	\$		\$	9
	B. Non-Facility Related*										
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related						\$	\$		\$	14
15	TOTALS (line 9+line14)						\$	\$		\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **HILLSBORO HSP EXTRA CARE FAC**# **8000879** Report Period Beginning: **07/01/03** Ending: **06/30/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	\$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999		8		
	2000		9		
	2001		10		
	2002		11		
	2003		12		
				FOR OHF USE ONLY	
				13	13
				14	14
				15	15
				16	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLSBORO HSP EXTRA CARE FAC COUNTY MONTGOMERY

FACILITY IDPH LICENSE NUMBER 8000879

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number HILLSBORO HSP EXTRA CARE FAC

8000879

Report Period Beginning:

07/01/03

Ending:

06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,014 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

THE NURSING FACILITY IS LOCATED WITHIN THE HOSPITAL FACILITY

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	35,683	1973	\$ 1,754	1
2					2
3	TOTALS	35,683		\$ 1,754	3

STATE OF ILLINOIS

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Facility Name & ID Number HILLSBORO HSP EXTRA CARE FAC

8000879

Report Period Beginning:

07/01/03

Ending:

06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	40		1975	\$ 374,188	\$ 5,539	VARIIIOUS	\$ 5,539	\$	\$ 355,363
5									
6									
7									
8									
Improvement Type**									
9	DOORS/PAINTING		1986	1,670		VARIOUS			1,670
10	PAINTING		1987	788		VARIOUS			788
11	OXYGEN VALVES		1988	2,243		10			2,243
12	CALL LIGHT REPAIR		1990	563		10			563
13	CALL SYSTEM		1991	14,563	971	15	971		13,108
14	OXYGEN ALARM SYSTEM		1992	1,331	89	15	89		1,075
15	TUB ROOM		1994	11,606	774	15	774		8,385
16	REMODEL EDF REC. ROOM		1994	7,820	782	10	782		6,387
17	EDF REMODEL		1997	14,040	1,670	7	1,670		14,040
18	47 BED PAN NOZ		1999	5,325	355	15	355		1,598
19	FLOORING		1999	822	82	10	82		369
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 434,959	\$ 10,262		\$ 10,262	\$	\$ 405,589		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 151,631	\$ 8,802	\$ 8,802	\$	VARIOUS	\$ 107,226	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 151,631	\$ 8,802	\$ 8,802	\$		\$ 107,226	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 588,344	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,064	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,064	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 512,815	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2005 \$ _____

13. _____/2006 \$ _____

14. _____/2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3		4	
		Facility							
		Drop-outs		Completed		Contract		Total	
1	Community College Tuition	\$		\$		\$		\$	
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wage (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$		\$		\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$							

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
 (c) For in-house training programs only. Do not include fringe benefit.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 852,882		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 609,000)	1,631,699		3
4	Supply Inventory (priced at)	363,189		4
5	Short-Term Investments	96,044		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	205,864		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>OTHER RECEIVABLES</u>	87,848		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,237,526	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	554,889		12
13	Land	249,885		13
14	Buildings, at Historical Cost	8,867,964		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,992,669		16
17	Accumulated Depreciation (book methods)	(8,643,233)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp) <u>ASSETS LTD. USE</u>	4,434,875		22
23	Other(specify): <u>CIP</u>	42,293		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,499,342	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,736,868	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,203,401	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	49,593		29
30	Accrued Salaries Payable	506,647		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,759,641	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,884,254		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,884,254	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,643,895	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,092,973	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,736,868	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,106,150	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,106,150	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	818,774	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(1,000,000)	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment	3,897	14
15	Other (describe) NET CHANGE IN INVESTMENTS	111,537	15
16	Other (describe) NET TRANSFERS TO/FROM	(4,954,791)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (5,020,583)	17
B. Transfers (Itemize):			
18	CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION	7,406	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 7,406	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,092,973	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number HILLSBORO HSP EXTRA CARE FAC

8000879

Report Period Beginning: 07/01/03

Ending:

06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,728,097	1
2	Discounts and Allowances for all Levels	(2,845,450)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,882,647	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,565,485	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9,565,485	8
	C. Other Operating Revenue		
9	Payments for Educator		9
10	Other Government Grants	19,250	10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	16,176	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	63,408	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient	1,487	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26,121	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126,442	23
	D. Non-Operating Revenue		
24	Contributions	3,897	24
25	Interest and Other Investment Income**	40,759	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,656	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,619,230	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	718,024	31
32	Health Care	8,817,934	32
33	General Administration	2,734,992	33
	B. Capital Expense		
34	Ownership	751,831	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	21,960	36
	D. Other Expenses (specify):		
37	PROVISION FOR BAD DEBTS	699,531	37
38	NET LOSS ON INVESTMENTS	56,184	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,800,456	40
41	Income before Income Taxes (line 30 minus line 40)**	818,774	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 818,774	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **HILLSBORO HSP EXTRA CARE FAC**# **8000879**Report Period Beginning: **07/01/03**

Ending:

06/30/04**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4		
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing			\$	\$	1	
2	Assistant Director of Nursing					2	
3	Registered Nurses					3	
4	Licensed Practical Nurses					4	
5	Nurse Aides & Orderlies					5	
6	Nurse Aide Trainees					6	
7	Licensed Therapist					7	
8	Rehab/Therapy Aides					8	
9	Activity Director					9	
10	Activity Assistants					10	
11	Social Service Worker:					11	
12	Dietician					12	
13	Food Service Supervisor					13	
14	Head Cook					14	
15	Cook Helpers/Assistants					15	
16	Dishwashers					16	
17	Maintenance Worker					17	
18	Housekeepers					18	
19	Laundry					19	
20	Administrator					20	
21	Assistant Administrator					21	
22	Other Administrative					22	
23	Office Manager					23	
24	Clerical					24	
25	Vocational Instruction					25	
26	Academic Instruction					26	
27	Medical Director					27	
28	Qualified MR Prof. (QMRP)					28	
29	Resident Services Coordinator					29	
30	Habilitation Aides (DD Homes)					30	
31	Medical Records					31	
32	Other Health Care(specify					32	
33	Other(specify)					33	
34	TOTAL (lines 1 - 33)			\$	*	\$	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries:			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services	Vendor/Payee	Type	Amount				Out-of-State Travel	\$
			\$					
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$
(If total legal fees exceed \$2500 attach copy of invoices.)			\$				TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

(See instructions.)

[illegible]

<p>Facility Name & ID Number <u>HILLSBORO HSP EXTRA CARE FAC</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union <u>YES</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>NO</u> If YES, give association name and amount _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>N/A</u> What was the average life used for new equipment added during this period? _____</p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. _____ Line <u>39</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u> If YES, give effective date of lease _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over: _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. <u>21,960</u> This amount is to be recorded on line 42 of Schedule V</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? <u>YES</u> If YES, attach an explanation of the allocation _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>8000879</u> Report Period Beginning: <u>07/01/03</u> Ending: <u>06/30/04</u> Page 23</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>YES</u></p> <p>(14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B <u>YES-HOSPITAL</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>NONE</u> Has any meal income been offset against related costs? <u>YES</u> Indicate the amount \$ <u>SEE MEDICARE CR</u></p> <p>(16) Travel and Transportation</p> <p>a. Are there costs included for out-of-state travel? <u>NO</u> If YES, attach a complete explanation _____</p> <p>b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such program during this reporting period. \$ <u>N/A</u></p> <p>c. What percent of all travel expense relates to transportation of nurses and patients? <u>N/A</u></p> <p>d. Have vehicle usage logs been maintained? <u>N/A</u></p> <p>e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u></p> <p>f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u></p> <p>g. Does the facility transport residents to and from day training? <u>NO</u> Indicate the amount of income earned from providing such transportation during this reporting period \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>YES</u> Firm Name: <u>KERBER, ECK & BRAECKEL, LLP</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>NO</u> If no, please explain <u>WILL BE FORWARDED WHEN FINISHED</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees _____</p>
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